MEDICAID PURCHASE PLAN PREMIUM
RECIPIENT / EMPLOYER ELECTRONIC FUNDS TRANSFER
INFORMATION AND INSTRUCTIONS

The Wisconsin Medicaid Purchase Plan requires information to enable the Medicaid Purchase Plan to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include but is not limited to information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02 [4] Wis. Admin. Code).

Under s .49.45 (4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to the Medicaid program administration such as payment of premiums by recipients. Failure to supply the information requested by the form may result in denial of Medicaid payment for services.

INSTRUCTIONS: This form may be used by recipients who are making their own payments, as well as employers who are withholding payments on behalf of employees who have Medicaid Purchase Plan (MAPP).

Fill out this form if you want the MAPP to automatically deduct funds from your checking or savings account the third of each month for your MAPP premium payment. Should the third fall on a weekend or holiday, funds will be taken from your account the following business day. To have your funds taken out automatically, fill out the section of the form that says “Complete the information below.” Employers must complete a separate form for each employee.

- **Receiving Bank / Savings and Loan / Credit Union**
  Enter the name of your bank, savings and loan, or credit union in the space. If it is a branch office, enter that information under “Branch.” Include the city, state, and ZIP code where your bank, savings and loan, or credit union is located. Use the information for the branch you visit most frequently.

- **Account Type**
  Check the box for the type of account, checking or savings, from which you would like the funds taken.

- **Bank Transit Routing Number and Bank Account Number**
  These numbers can be found on the bottom of your checks and deposit slips. **You must attach a voided check or deposit slip to the Electronic Funds Transfer (EFT) form.** The bank transit routing number is the first nine digits. The following number, up to 17 digits in length, is the bank account number. If you are unsure of these numbers, contact your bank, savings and loan, or credit union.

- **Employer Signature if Applicable**
  If the recipient decides to pay the premium payment using employer wage withholding, and the employer chooses to pay using EFT, the employer will need to fill out and sign the EFT form.

- **Names(s) and Signature(s)**
  Print the name of the account’s owner, and the name of the account’s co-owner if it is a joint account. Next, fill in the Medicaid identification number of the person who is the case head, or the person in charge of MAPP for the family.

The account owner and account co-owner, if it is a joint account, then need to sign and date the form.

If you have any questions regarding the above information, call 1-888-907-4455.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13023 (12/01)

STATE OF WISCONSIN

MEDICAID PURCHASE PLAN PREMIUM
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INSTRUCTIONS: Type or print clearly. Before completing this form, read Information and Instructions on the reverse side of this form. **You must attach your voided check or deposit slip to this form for verification of correct information.**

Name(s) on Account

Medicaid Purchase Plan

I give permission to the Wisconsin Medicaid Purchase Plan (MAPP) to begin taking money out of my (our) checking/savings account named below, at the bank/savings and loan/credit union named below.

Complete the information below.

Receiving Bank / Savings and Loan / Credit Union	Branch

City of Bank / Savings and Loan / Credit Union	State	ZIP Code

Account Type: ☐ Checking ☐ Savings

Bank Transit Routing Number (nine-digit number)

Bank Account Number (Maximum 17 digits)

This permission is to remain in effect until MAPP has received written notice from me (either of us) of its ending, in order to allow MAPP and Firstar Bank a reasonable opportunity to act on it. If I lose my MAPP eligibility, I understand my Electronic Funds Transfer will be ended.

Account Owner's Name	Medicaid Identification Number — Case Head

SIGNATURE — Account Owner	Date Signed

SIGNATURE — Account Co-owner (if applicable)	Date Signed

SIGNATURE — Employer (if applicable)	Date Signed

All written debt authorizations must provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization.

DISTRIBUTION: Mail completed form to:

RESET FORM

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738
Telephone: 1-888-907-4455
Fax: 1-608-221-8185